No. 97-689

In The

Supreme Court of the United States

October Term, 1997

BONNIE L. GEISSAL as representative of the Estate of JAMES W. GEISSAL, deceased,

Petitioner,

vs.

MOORE MEDICAL CORP., GROUP BENEFIT PLAN OF MOORE MEDICAL CORP. and HERBERT WALKER,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

BRIEF FOR PETITIONER

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QUESTIONS PRESENTED FOR REVIEW

I. Does pre-existing spousal/dependent health insurance coverage require the termination of continuation coverage under the Consolidated Omnibus Budget Reconciliation Act [COBRA] for an otherwise qualified beneficiary?

II. If Congress intended that coverage may be continued where there is a "significant gap" in coverage between the two policies, should the courts decide whether a "significant gap" exists? If so, how?

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OPINIONS AND JUDGMENTS BELOW

The district court found against Petitioner and in favor of Respondents on Count's I and II of her complaint, *Bonnie Geissal v. Moore Medical Corp., et al.*, No. 4:94CV1263DDN (March 19, 1996), denying plaintiff's/appellant's motion for summary judgment and finding on the Court's own motion summary judgment in favor of Respondents, which is published at 927 F. Supp. 352, and is reprinted at 35a-55a. Judgment was entered by the Honorable David D. Noce, United States Magistrate Judge, Eastern District of Missouri. The Eighth Circuit Court of Appeals' affirmance of the decision of the district court is found at 114 F.3d 1458 (8th Cir. 1997).

STATEMENT OF SUPREME COURT JURISDICTION

The district court had jurisdiction of this action pursuant to 28 U.S.C. § 1331, and under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. § 1001, *et seq.*, and particularly 29 U.S.C. §§ 1132(a) and 1161. During the course of the proceedings in the district court, the original plaintiff died and the personal representative of his estate was substituted as party plaintiff. She is the petitioner herein.[1] Final judgments were entered on April 16, 1996 pursuant to Rule 54(b), Federal Rules of Civil Procedure by the Magistrate Judge acting under consent given pursuant to 28 U.S.C. § 636(c)(1). Petitioner filed timely notice of her appeal pursuant to 28 U.S.C. § 1291 on May 3, 1996. Fed. R. App. P. 4(a). The Eighth Circuit affirmed on June 10, 1997, and Petitioner's motions for rehearing were denied on July 30, 1997. Petitioner filed a timely Petition for Writ of Certiorari, pursuant to Supreme Court Rule 13.1 on October

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1. Petitioner Bonnie L. Geissal maintains this action "as beneficiary and representative of the Estate of James W. Geissal, deceased, individually, and in a representative capacity on behalf of the Group Benefit Program of Moore Medical Corp." The Respondents are: "Moore Medical Corporation; Group Benefit Plan of Moore Medical Corp.; [and] Herbert Walker."

20, 1997, which was within 90 days of the denial of rehearing. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. § 1254.

PERTINENT STATUTES

The text of the relevant statutes in this case is set forth in an appendix to the brief.

STATEMENT OF THE CASE

The essential question in this case is the right of plaintiff to continue his health insurance coverage under the provisions of the Comprehensive Omnibus Budget Reconciliation Act ("COBRA"), incorporated as an amendment into the provisions of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1161, *et seq.*

A. Facts

James W. Geissal, the original plaintiff in this action, while employed by defendant/appellee Moore Medical Corporation, was entitled to health care benefits from a group plan established by the employer. Mr. Geissal's wife Bonnie worked for Trans World Airlines which provided for its employees and their spouses health care benefits through its Aetna Life Insurance Company group health plan. Dual coverage thus existed during Mr. Geissal's employment.

Mr. Geissal suffered from solid tumor cancer, a condition that usually means metastases and an eventual and painful death after long and expensive treatment and care that could easily consume one's life savings. Mr. Geissal's employer learned about the cancer. Mr. Geissal was terminated. At the time of termination defendants assured Mr. Geissal of eligibility for COBRA continuation, and encouraged him to so elect to continue his coverage and pay premiums, which he did. As a result, he did not seek to replace the coverage by defendants when he was first terminated, believing

the dual coverage he was assured he would have by paying COBRA premiums, was still sufficient. Only after requests came in for payment for the mounting expenses of cancer treatment did defendants advise Mr. Geissal that he was not entitled to and ineligible for COBRA coverage. The reason given was that Mr. Geissal remained eligible to receive health benefits under his wife's group policy. They proposed to pay back his premiums. This suit ensued.

B. Court History

The suit brought by plaintiff/appellant contained four counts: the first alleged a straightforward COBRA violation; Count II alleged liability to continue COBRA health insurance on an estoppel theory; Count III alleged defendants had waived any right not to offer COBRA continuation; and finally Count IV alleged the failure of the plan administrator to carry out his duty. App. 14a.

Plaintiff moved for summary judgment on liability issues. App. 25a. Mr. Geissal filed an uncontested affidavit. App. 28a. While the motion was under submission Mr. Geissal died, and the current appellant substituted. App. 34a. The Magistrate Judge denied summary judgment to plaintiff, but granted summary judgment *sua sponte* to Respondents on Counts I and II, leaving open the other two counts. App. 35a. The district court then ordered the Clerk to enter final judgments with the appropriate findings under Rule 54(b), FRCP, on Counts I and II, in favor of Respondents and against the Petitioner. App. 56a. Final judgment on Counts I and II were then entered. App. 58a. The United States Court of Appeals for the Eighth Circuit affirmed the judgment.

C. Statutory And Interpretive History

To put this case in proper context, it is appropriate to set forth the history of legislative and judicial development of the issues in

this case. The Eighth Circuit's analysis in *Geissal* consisted essentially of a choice between "at least two separate and irreconcilable interpretations of the law." 114 F.3d at 1465. After setting forth its view of these developments, 114 F.3d at 1461-63, the Eighth Circuit chose in favor of a formulation developed by the Eleventh Circuit, 114 F.3d at 1463, and substantially modified by several district courts which purported to follow the Eleventh Circuit approach. 114 F.3d at 1464-65 ("Upon reflection, and with the benefit of several years of case law developing the relevant standard, . . ."). In reaching this result, the Eighth Circuit explicitly rejected the approach adopted by the Seventh and Tenth Circuits. 114 F.3d 1462-63. Because the Eighth Circuit's decision relies almost exclusively on developments in other cases, the key to comprehending the Eighth Circuit approach is understanding this history.

1. Original Statute

As originally enacted, the statutory provision at issue read as follows:

> Section 602(2) PERIOD OF COVERAGE — The coverage must extend for at least the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following:
>
> * * *
>
> D. REEMPLOYMENT OR MEDICARE ELIGIBILITY. — The date on which the qualified beneficiary first becomes, after the date of the election —
>
> (i) a covered employee under any other group health plan. . . .
>
> * * *

> E. REMARRIAGE OF SPOUSE. — In the case of an individual who is a qualified beneficiary by reason of being the spouse of a covered employee, the date on which the beneficiary remarries and becomes covered under a group health plan.

As part of the Tax Reform Act of 1986, which it enacted only a few months later, Congress sought to revise this language to make it clear that any after-acquired group health care — such as when a spouse obtains employment and group coverage for dependents — could terminate COBRA rights. The section thus read as follows:

> D. GROUP HEALTH PLAN COVERAGE OR MEDICARE ELIGIBILITY. — The date on which the qualified beneficiary first becomes, after the date of the election —
>
> (i) covered under any other group health plan (as an employee or otherwise). . . .

There is little extrinsic evidence of what Congress intended in amending 29 U.S.C. § 1162(2)(D)(i) in 1986, but the purpose of this amendment is easy enough to discern from the language: As originally enacted, the law provided at § 1162(2)(D)(i) that continuation coverage would terminate upon an individual being first after the election covered under another plan as an employee. Section 1162(2)(E) further provided that if the individual was a qualified beneficiary by reason of being a spouse, that person's coverage would also later terminate upon being covered by another group plan through remarriage. Congress found these situations too limiting, in that there were other ways by which individuals, after making the election, could first become covered under another group health plan. For example, an eligible dependent who obtained COBRA coverage by reason of death or divorce could obtain new coverage as an eligible dependent of another's policy when the

spouse became entitled to group health coverage. So, the statue was amended and broadened to cover almost any kind of group health coverage which the participant or qualified beneficiary acquired.

2. Oakley v. City of Longmont, 890 F.2d 1128 (10th Cir. 1989) ("Oakley"), cert. denied, 494 U.S. 1082 (1990)

The facts in *Oakley* were straightforward. The plaintiff in that case had been covered on a group plan through his employer until he was severely injured in an automobile accident. After some time, he was declared ineligible for further coverage through his employer, and he sought to elect COBRA continuation coverage. The City of Longmont, however, denied his request because he was already covered as a dependent on his wife's policy.

Because Mr. Oakley had suffered a qualifying event and was an appropriate candidate for continuation coverage, the Tenth Circuit in *Oakley* dissected the language of 42 U.S.C. § 300bb-2(2)(D)(i) — which is the state and local government version of the language here at issue in 29 U.S.C. § 1162(2)(D)(i).[2] After first noting that the requirement that the disqualifying "other group" coverage must first cover the individual "after the date of the election", the court held that the language surely must mean what it says:

> [W]e believe the plain meaning of this subsection cannot be construed to include a spouse's pre-existing group plan as a condition to terminate continuation coverage. Indeed, Mr. Oakley did not

2. The *Oakley* court actually reviewed 42 U.S.C. § 300bb-2(2)(D)(i) which relates to continuation coverage provided by government entities, but the court noted that parallel language exists in Title 29 (ERISA) under which *Lutheran Hospital* and this instant case were brought. COBRA covers more than plans subject to ERISA. *See McGee v. Funderburg, infra.*

> "first become" covered under his wife's policy after the qualifying event that resulted in his termination from the City's employment. Nor did Congress intend a covered employee's termination to become a condition triggering "other coverage" under a spouse's pre-existing group plan. Consequently, only when we read the language of subsection (i) to refer to other coverage occurring after the qualifying event, do we preserve its plain meaning and give effect to Congress' intent. 890 F.2d at p. 1132.

The court verified this conclusion through an exploration of the legislative history behind this particular language. It first examined the history of the provision as contained in a House Conference Report, and concluded that continuation coverage would terminate the day ***after*** the terminated employee obtained other coverage through employment, reemployment, or remarriage, but only if these events occurred after the individual had first elected continuation coverage. By implication, the *Oakley* court observed, coverage which was in place through marriage ***before*** the continuation coverage was elected would not impair the ability of the participant to continue his coverage from the former employer.

The Tenth Circuit then went on to speculate about the intent of Congress based on "a reading of the statute as a whole." 890 F.2d at 1132. The lower court in the *Oakley* case had acted in the belief that Congress "was concerned with providing minimal coverage and avoiding overlapping continuation coverage". 890 F.2d at 1133. But in reversing its district court the Tenth Circuit in *Oakley* held that Congressional intent as expressed in the statute was that the participant should be entitled to coverage identical to that which he or she had enjoyed prior to the qualifying event, until the securing of other coverage through a subsequent event, such as remarriage or other employment, terminated the continuation rights. The court then went on in *dicta:*

> Surely the facts of this case illustrate the precise gap in coverage which troubled Congress. Mr. Oakley was terminated because of a catastrophic event which would have put his family at risk and jeopardized his treatment had the continuation rules not been in effect to maintain his rehabilitation for a limited period of time.

890 F.2d at 1133. Thus, the *Oakley* court confronted a situation in which the participant's serious condition would not have been covered by the spouse's pre-existing coverage, but it did not rely on that fact in reaching its decision; rather, it adhered to the plain language of the statute in finding that such coverage did not preclude continuation coverage for the plaintiff.

3. Revised Statute

Ten days after the Tenth Circuit's decision in *Oakley*, the clause was amended for the last time before the facts in this case arose to read as follows:

> D. GROUP HEALTH PLAN COVERAGE OR MEDICARE ENTITLEMENT.— The date on which the qualified beneficiary first becomes, after the date of the election —
>
> > (i) covered under any other group health plan (as an employee or otherwise), which does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary. . . .

Nothing in the statute or legislative history suggested that this new language had anything to do with the Tenth Circuit's decision or dicta in *Oakley*. Nevertheless, the legislative history of the amendment does suggest that *Oakley* correctly perceived the intent of the 99th Congress — which passed the law — at least from the perspective of the 101st Congress:

> This provision is intended to carry out the original intent of the health care continuation rules, which was to reduce the extent to which certain events, such as the loss of one's job, could create a significant gap in health coverage. If a qualified beneficiary is covered under another plan that excludes coverage for a preexisting condition, he or she is at risk during the period of exclusion. If the qualified beneficiary is willing to elect health insurance continuation coverage from a previous employer as well, that is a strong indication that the new employer has left a significant gap in coverage.

H.R. Rep. No. 101-247, 101st Cong., 1st Sess., *reprinted in* 1989 U.S. Code Cong. & Admin. News 1906, 1943.

4. Brock v. Primedica, Inc., 904 F.2d 295 (5th Cir. 1990) ("Brock")

One year later, the Fifth Circuit in *Brock* unwittingly began the process that led the lower courts to make an utter mess of things. The *Brock* court decided that a qualified beneficiary who resigned from her job with pre-existing coverage from her husband's policy could elect COBRA coverage only if there was a "significant gap" in the pre-existing coverage. 904 F.2d at 297. Although the *Brock* court purports to rely on *Oakley*, for a "gap" test — no such test was ever there: the Fifth Circuit simply extrapolated it from dicta. *National Companies Health Benefit Plan v. St. Joseph's Hospital, Inc.*, 929 F.2d 1558, 1569 (11th Cir. 1991) (noting that the "gap" language arose from Tenth Circuit dicta, and criticizing the Fifth Circuit's reasoning in *Brock*). The Fifth Circuit also relied on the "gap" references in the House committee report regarding the 1989 amendments set forth above. The problem was — of course — that these amendments — which created an exception to termination for pre-existing *conditions* — did not address the question *Oakley* resolved concerning whether COBRA benefits could be terminated due to pre-existing *coverage*.

No mention of any "gap" appears anywhere in any statute. *Brock* ignored the main thrust of *Oakley*: the plain language of the operative provisions of the statute — which remained unchanged — required the continuation of benefits despite pre-existing coverage.

Fortunately for Karen Brock, there was actually no difference between the benefits she would have received under the COBRA policy and what was actually paid under her husband's policy. Elsewhere, the "gap" test would make a difference.

5. National Companies Health Benefit Plan v. St. Joseph's Hospital, Inc., 929 F.2d 1558 (11th Cir. 1991) ("National Companies")

In *National Companies* the participant and his wife paid out approximately $6,700 in medical expenses related to the birth of twins which would otherwise have been covered by the participant's insurance. The participant was saddled with responsibility for payment because the participant's COBRA coverage was terminated as a result of the wife's pre-existing plan. 929 F.2d at 1571.

Relying on titles in the legislative history of the Tax Reform Act of 1986 which amended § 1162(2)(D)(i), the Eleventh Circuit claimed in *National Companies*, that Congress intended for the termination of COBRA rights to occur:

> upon coverage by [an]other group health plan *rather* than upon re-employment or remarriage. Thus, it appears that Congress intended that the obtention, in any manner, of almost any group health coverage would justify and ERISA-plan sponsor's termination of continuation coverage, and that Congress amended ERISA to effectuate this intent. In the absence of a clear expression by Congress contrary to this position, we will not follow the Tenth Circuit's lead in limiting the plainly expansive language of ERISA.

929 F.2d at 1570-71 (citations omitted) (emphasis by court).

Thus, reaching deep for first principles, the Eleventh Circuit bases its decision on the premise that Congress broadly drafted the expansive language in COBRA and ERISA to effectuate the purpose of *denying* insurance coverage to qualified beneficiaries. This is a remarkable finding given that COBRA by its effect, and ERISA by its terms, seem to have been designed primarily to protect, not employers, but working people. *See, e.g.*, 29 U.S.C. § 1001(b). Perhaps mindful of the surprising nature of this finding, and concerned about the rather harsh consequences this principle would cause if taken to its logical conclusion, the *National Companies* court completely reverses course in the next paragraph. Finding that where there is a "significant gap" in coverage:

> the employee is not truly "covered" by the preexisting group health plan, as that term is used by Congress to effectuate its intent; the employee, despite his other coverage, will be liable personally for substantial medical expenses to his and his family's detriment. Denying coverage in that setting would serve to frustrate, rather than foster, Congress' clear intentions.

929 F.2d at 1571. Nevertheless, the Eleventh Circuit decided that the $6,700 sum ***did not*** constitute a "significant gap" in coverage, because this sum was created by the lack of dual coverage, rather than a difference in the terms of the respective plans.[3]

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3. Interestingly, the Eighth Circuit held for this case that a $7500 sum would be sufficient to create a "significant gap" if it were the consequence of a difference in the terms of two plans. *McGee v. Funderburg*, 17 F.3d 1122, 1126 (8th Cir. 1994).

The Eleventh Circuit's decision is as paradoxical as it is perplexing: First the Eleventh Circuit invents an intent to deny coverage in almost every situation where there is dual coverage through what, to say the least, is an aerobic exercise in statutory construction. Then, while seeming to entirely disagree with the Fifth Circuit's reasoning in *Brock*, the Eleventh Circuit creates a completely contrary legislative intent out of whole cloth as a gloss on the term "covered" — which preceded any COBRA amendment — in order to justify the Fifth Circuit's mistaken "gap" approach. 929 F.2d at 1569. *See Lutheran Hospital of Indiana v. Business Men's Assurance Co. of Am.*, 51 F.3d 1308, 1313-14 (7th Cir. 1995). It then defines the concept of "significant gap" not in terms of whether the second policy would cover significant costs that otherwise would be absorbed by the qualified beneficiary, or whether the beneficiary "is willing to elect health insurance continuation coverage from a previous employer as well [as preexisting coverage]," H.R. Rep. No. 101-247, 101st Cong., 1st Sess., *reprinted in* 1989 U.S. Code Cong. & Admin. News 1906, 1943, but whether coverage under the participant's plan alone would put the family in a better position than coverage under the spouse's plan. 929 F.2d at 1571.

6. The National Companies Progeny

Without any legislative warrant or guidance as to how to carry out the *National Companies* analysis, courts adopting the Eleventh Circuit's "significant gap" test began to set out to compare the adequacy of different policies as if they were alternatives when they were not. This led to a variety of methods of analysis and results which certainly would have surprised the Congressional supporters of COBRA, of which the following are examples:

- In *Lutheran Hospital of Indiana v. Business Men's Assurance Company of America*, 845 F. Supp. 1275 (N.D. Ind. 1994), *reversed*, 51 F.3d 1308 (7th Cir. 1995), the court applied the *National Companies* analysis to find that a $35,000 personal patient liability created by a $250,000

annual limit in the terms of the alternate insurance policy was not a "significant gap" in coverage — even though the COBRA plan contained no annual limit — because the significance of this difference between the two policies would not have been apparent at the time the employee elected COBRA coverage. 845 F. Supp at 1288-89.

- The court in *Daniel v. Master Health Plan, Inc.*, 864 F. Supp. 1399 (S.D. Ga. 1994), relied on *National Companies* and the district court's decision in *Lutheran Hospital* to hold that an $800,000 shortfall in coverage for treatment incident to a catastrophic accident did not create a "significant gap" in coverage because the relevant differences in exclusions and limitations between the two plans were not based on a preexisting condition of the beneficiary.[4] *Id.* at 1406.

- In *Taylor v. Kawneer Co. Comprehensive Medical Expense Plan*, 898 F. Supp. 667 (W.D. Ark. 1995), the court relied on the *National Companies* analysis — as further extrapolated by *Daniel* — to find that no "significant gap" was created by a provision in the pre-existing plan imposing a $100,000 cap in benefits for newborns, even though this created a $121,000 patient liability incident to an infant's premature birth.

- Finally, in *Liberty Life Assurance v. Toys "R" Us, Inc.*, 901 F. Supp. 556 (E.D.N.Y. 1995), the court — purporting to rely on *National Companies* — held that the "significant gap" must be caused specifically "by a limitation on coverage for a pre-existing condition," *id.* at 564, in order to prevent the termination of benefits under COBRA, thereby imposing substantial liability for $153,000 in bills related to an autologous bone marrow transplant on the otherwise qualified beneficiaries and their subrogees.

4. The court nevertheless found that the shortfall was covered under an estoppel theory. 864 F. Supp. at 1407.

Curiously, this line of cases — as developed in the lower courts — did not assign any meaning to the original language of paragraph 1162(2)(D), concluding in essence that its meaning could only be derived from the 1989 amendment to clause 1162(2)(D)(i) regarding "exclusion[s] or limitation[s] with respect to any pre-existing condition of such beneficiary. . . ." Yet the none of the potential "gaps" which concerned the courts in *National Hospital*, *Brock*, and *Oakley* were the result of a pre-existing condition, exclusion or limitation. *See Lutheran Hospital of Indiana, Inc. v. Saint Joseph Medical Center*, 51 F.3d 1308, 1314 (7th Cir. 1995) Straining to apply the logic of *National Companies*, the *National Companies* progeny abandoned the Eleventh Circuit's reasoning, which at least made pretence of referring to the language of the statute that Court of Appeals purported to be interpreting.

7. Lutheran Hospital of Indiana, Inc. v. Saint Joseph Medical Center, 51 F.3d 1308 (7th Cir. 1995) ("Lutheran Hospital")

Reversing the first of the *National Company* progeny, the Seventh Circuit in *Lutheran Hospital* concluded that there are two things wrong with the *National Company* analysis: (1) it ignores the prefatory language in § 1162(2)(D) which requires for discontinuation that the coverage ***first*** arise ***after*** the election; and (2) it makes a technical correction of statutory language into something it is not.

The Seventh Circuit in *Lutheran Hospital* relies primarily on what all the other cases should have: the fact that the plain language of 29 U.S.C. § 1162(2)(D) "is sufficiently clear in its context" to demonstrate Congress's intent that an employee would not lose their right to continuation coverage unless "he or she chooses after the election date to accept coverage under another group health care plan." 51 F.3d at 1312 (citation omitted). It then reviewed what Congress did in enacting and then in amending 29 U.S.C. § 1162(2)(D)(i) in 1986 to verify that the plain meaning was "reasonable" and therefore not absurd. 51 F.3d at 1312. It found

that: "[t]he statutory distinction between pre-existing and after acquired health care is reasonable [because it] facilitates the preservation of the beneficiary's health care status quo." *Id.*

The Seventh Circuit does engage in a foray into legislative history, but only as an exercise in trying to figure out and debunk "how and from where" the district court in that case, and Eleventh Circuit in *National Companies* divined an entirely contrary Congressional intent, which the Seventh Circuit notes "is not clear." 51 F.3d at 1312. The Court of Appeals points out that "there is little legislative history which illuminates Congress's intent in enacting COBRA and none which relates to the timing provision at issue here." 51 F.3d at 1313. There is certainly nothing in the legislative history to "undermine the statutory distinction between coverage accepted after election and preexisting double coverage." 51 F.3d at 1312. *Oakley* and *Lutheran Hospital* recognized that the phrase "first becomes after the election," still remained in the amended law, while *National Companies* and its progeny chose to read the amended statute as if that language had been eliminated.

In adhering to the plain language of the statute, the Seventh Circuit avoided not only a manifest injustice to the plaintiff in that case, but also avoided the "morass" into which the *National Companies* courts so willingly waded, that of determining what constituted a "gap" in coverage which would justify extension of COBRA coverage even if the qualified beneficiary had pre-existing coverage through another source, such as a spouse. 51 F.3d at 1314-15. The Seventh Circuit says these "gap" issues should not even be addressed, and that it is definitely not for the courts to make adequacy-of-coverage decisions for the worker facing what could be monumental expenses. What is compelling is the participant's perception as to whether he wants to pay a premium of up to 102% of cost, to "maintain their prior level of coverage." It is the insured "who bears the risk and pays the premium" who is

the best determiner of what is acceptable comparable coverage.[5] 51 F.3d at 1314.

Aside from being unworkable, the Seventh Circuit in *Lutheran Hospital* concluded the "significant gap" methodology is not supported in the statute. In 1989, Congress amended the subject provision in order to provide that if subsequent coverage contains a pre-existing condition exclusion, that subsequent group coverage could not terminate COBRA rights. A pre-existing condition clause is a very specific provision in any insurance policy; it cannot be expanded to contemplate gaps in coverage, exclusions, or other plan provisions which may differentiate one plan from another and render its coverage of much less value to the recipient. Congress at the time it amended the statue certainly could have included language to cover the "gap" issue, but it chose not to do so. 51 F.3d at 1314.

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5. The Seventh and Tenth Circuits were not the only courts to make this observation: In *King v. John Hancock Mutual Life Ins. Co.*, 500 N.W. 2d 619 (S.D. 1993) the South Dakota Supreme Court, while noting a possible gap in coverage for the plaintiff if continuation coverage was not allowed, observed that the possibility of such a gap was precisely why Congress:

> subscribe[d] to the language "after the date of the election". People are to be given the opportunity to obtain new coverage without losing equivalent coverage in the interim. In other words, a person covered by both Medicare and a group health plan at termination will keep the same coverage until that person, not the insurance company, elects to choose otherwise. Therefore, if a gap in coverage occurs, it will be due to the individual purposely accepting less coverage. . . . Congress did not intend a covered employee's termination to become a condition triggering use of pre-existing coverage, whether it be Medicare or otherwise. "After the date of the election" plainly means "after". [Citations omitted]. 500 N.W. 2d at 622.

8. Geissal v. Moore Medical Corp., 114 F.3d 1458 (8th Cir. 1997)

Having detailed the history of the development of the law up to *Geissal*, it is not at all difficult to place the Eighth Circuit's decision in context. In the case at bar, after setting forth the differing judicial viewpoints on the matter at issue, the Eighth Circuit, by its own formulation, took this occasion to "explicitly follow the approach adopted by the Eleventh Circuit." 114 F.3d at 1463. Accordingly, on the strength of vague statements on the broad purposes of the statute in House committee reports, the Court found itself:

> . . . in disagreement with the Seventh Circuit's decision that continuation benefits were crafted to allow an individual to maintain his insurance "status quo." Rather, we are convinced that Congress was fundamentally interested in making affordable health care temporarily available to those who otherwise would find themselves "without any health insurance coverage."

114 F.3d at 1463 (*quoting*, H.R. Rep. No. 99-241, pt. 1, at 44 (1995), *reprinted in*, 1986 U.S. Code Cong. & Admin. News 579, 622) (other citations omitted).

The Eighth Circuit then aligned itself with the *National Companies* progeny in: (1) adopting the "significant gap" test from cases interpreting committee reports; 114 F.3d 1464; (2) finding that the "significant gap" test as formulated by Eleventh Circuit would be too burdensome on employers because it would require a *post hoc* determination of whether termination of COBRA benefits was warranted; and (3) reformulating the "significant gap" test so that it did not pertain to the statutory language of COBRA, but to the 1989 exception, focusing on "whether there is any exclusion or limitation on the patient's preexisting condition, and with a view to the treatment the beneficiary may forseeably require."

114 F.3d at 1465. To avoid the effect of the term "after," the Eighth Circuit created the fiction that Ms. Geissal's pre-existing insurance coverage did not become truly effective until after Mr. Geissal's election was exercised.

Predictably, the effect was to find that Mr. Geissal's benefits could be denied. This Court's review followed:

SUMMARY OF THE ARGUMENT

The essential question in this case is the right of a terminated and dying employee to continue his health insurance coverage under the provisions of the Comprehensive Omnibus Budget Reconciliation Act ("COBRA"), incorporated as an amendment into the provisions of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1161, *et seq.*, when until that termination the employee had dual coverage by reason of existing coverage provided by his spouse's employer. The statute provides in 29 U.S.C. § 1162(2)(D)(i) that COBRA continuation coverage could only be suspended on:

> The date on which the qualified beneficiary ***first*** becomes, ***after*** the date of the election —
>
> > (i) covered under any other group health plan (as an employee or otherwise) which does not contain any exclusion or limitation with regard to any pre-existing. (emphasis supplied)

The issue is whether the spouse's pre-existing coverage that gave plaintiff dual coverage before a COBRA-qualifying event, provides reason to excuse plaintiff's employer from continuing to assure such coverage, and if it does, under what further factors and circumstances.

The law requires that the phrases "The date on which" and "first becomes, after the date of the election — covered . . ." be

given their plain meaning. In light of the clear language of the statute at issue, it is somewhat surprising that there has been significant litigation about it. The statute clearly provides that an employee's COBRA rights terminate on the date on which he ***first*** becomes ***after*** the election date entitled to coverage under any other group plan. That is, only other group coverage which is obtained after the date of the election can preclude COBRA entitlement and selection. Definitions of the relevant terms in contemporaneous dictionaries, and the meaning of the phraseology in legal and general usage require this result. A contrary conclusion would violate the principle that courts are to give effect, wherever possible, to all provisions of a statute — a cardinal canon of statutory interpretation made particularly cogent by the underlying structure of ERISA and COBRA, of which the relevant provision is a part. The consistent use of similar phraseology elsewhere in the same section of the statute, the use of mandatory language in the underlying statute, and the fact that the provision at issue is an exception to mandatory language bolsters the conclusion mandated by the statute's plain meaning.

It cannot be said that absurd results are produced by giving the statute its natural and ordinary meaning. Reading the statute as preserving the health insurance status quo of employees and their families who experience qualifying events serves important Congressional goals of insuring the continued availability of health care in medical crises, and preventing the financial ruin of families in times of great misfortune. In contrast, reading the statute as if it contained language from congressional committee reports — as some circuits have done — leads to a host of paradoxes and absurdities.

Absent absurdity, the Court should not overturn the statute's specific provisions on the basis of some Court of Appeals' broad notions of statutory intent. The legislative history of the continuation of coverage provisions in COBRA is very sparse and generalized. There is no legislative history that precisely discusses the meaning of the phrase in question, and the minimal general

discussion about the overall legislative purposes of COBRA contain isolated statements which both contradict and, to a far lesser extent, support Respondents' arguments. There was no indication that the language literally would thwart the obvious purposes of the act, and no conclusive statement in the legislative history that would undermine the ordinary understanding of the statutory language. Furthermore, were there doubts about the ordinary meaning of the language, the interpretation urged by Petitioner would be the better approach toward remedying the underlying policy problems which concerned Congress.

ARGUMENT

I.

THE COURT MUST INTERPRET UNAMBIGUOUSLY WORDED STATUTES BASED ON A NATURAL READING OF THE TEXT IF POSSIBLE.

"The starting point in statutory interpretation is 'the language of the statute itself.' " *Ardestani v. Immigration and Naturalization Service*, 502 U.S. 129, 135 (1991) (O'Connor, J.) (citations and parenthesis omitted). *See also Estate of Cowart v. Nicklos Drilling Co.*, 505 U.S. 469, 475 (1992) (Kennedy, J.). The Court has consistently held that there is a "strong presumption 'that the legislative purpose is expressed by the ordinary meaning of the words used.' " *Ardestani*, 502 U.S. at 136 (*quoting*, *American Tobacco Co. v. Patterson*, 456 U.S. 63, 68 (1982) (*quoting*, *Richards v. United States*, 369 U.S. 1, 9 (1962))).

"The 'strong presumption' that the plain language of the statute expresses congressional intent is rebutted only in 'rare and exceptional circumstances.' " *Ardestani*, 502 U.S. at 135 (*quoting*, *Rubin v. United States*, 449 U.S. 424, 430 (1981)). Where the statutory text is clear, respondent's burden to persuade the Court that Congress intended to create a contrary "special rule . . . is exceptionally heavy." *Union Bank v. Wolas*, 502 U.S. 151, 156

(1991) (Stevens, J.) (*citing*, *United States v. Ron Pair Enterprises, Inc.*, 489 U.S. 235, 241-42 (1989)).

II.

THE ANALYSIS NEED GO NO FURTHER THAN THE UNAMBIGUOUS TERMS OF THE STATUTE.

The plain meaning rule is the single most "cardinal canon" of statutory interpretation. *Connecticut Nat'l Bank v. Germain*, 503 U.S. 249, 253 (1992) (Thomas, J.) The Court recently enunciated this position as follows:

> We have stated time and again that courts must presume that a legislature says in a statute what it means and means in a statute what it says there. (citations omitted). When the words of a statute are unambiguous, then, this first canon is also the last: "judicial inquiry is complete."

Connecticut Nat'l Bank, 503 U.S. at 253-54 (*citing*, *Rubin*, 449 U.S. at 430; *Ron Pair Enterprises*, 489 U.S. at 241). *See also Estate of Cowart v. Nicklos Drilling Co.*, 505 U.S. at 475 ("[W]hen a statute speaks with clarity to an issue judicial inquiry into the statute's meaning, in all but the most extraordinary circumstance, is finished." (citation omitted)).

From this perspective, any discussion of the legislative history of a textually unambiguous statute is "a waste of research time and ink [and a] false and disruptive lesson in the law." *Conroy v. Aniskoff*, 507 U.S. 511, 519 (1993) (Scalia, J. concurring). *See also West Virginia Univ. Hospitals, Inc. v. Casey*, 499 U.S. 83, 98-99 (1991) ("Where [a statute] contains a phrase that is unambiguous — that has a clearly accepted meaning in both legislative and judicial practice — we do not permit it to be expanded or contracted by the statements of individual legislators or committees during the course of the enactment process.") In the face of this "cardinal

canon," contrary agency interpretations are entitled to no deference, *see, e.g., Chicago v. Environmental Defense Fund*, 511 U.S. 328, 339 (1994); *Estate of Cowart v. Nicklos Drilling Co.*, 505 U.S. at 476, difficult constitutional issues cannot be construed away, *Salinas v. United States*, __ U.S. __ (1997), 118 S. Ct. 469, 475 (1997), and contrary Supreme Court precedent must fall, no matter how well-established. *Hubbard v. United States*, 514 U.S. 695, 708 (1995) (Stevens, J.) (*overruling United States v. Bramblett*, 348 U.S. 503 (1955)). There is no novelty in assigning primacy to this canon: throughout its history, this Court and virtually all others have recognized this doctrine as required by the Constitution's separation of powers, and the limited nature of the judicial function. *See Bate Refrigerator Co. v. Sultzberger*, 157 U.S. 1, 37-38 (1895) (Harlan, J.) (*citing, Denn v. Reid*, 35 U.S. (10 Pet.) 524, 527 (1836) and *United States v. Fisher*, 6 U.S. (2 Cranch) 358, 386 (1803) (Marshall, C.J.)).

> To allow a court . . . to say that the law must mean something different from the common import of its language, because the court may think that its penalties are unwise or harsh, would be to make the judicial superior to the legislative branch of government, and practically invest it with the law-making power.

Rhode Island v. Duggan, 15 R.I. 403, 409, 6 A. 787 (1886).

III.

A NATURAL READING OF SECTION 1162(2)(D) OF TITLE 29 UNITED STATES CODE DOES NOT REQUIRE THE TERMINATION OF COBRA BENEFITS DUE TO COVERAGE UNDER A HEALTH INSURANCE POLICY BEFORE THE DATE OF COBRA ELECTION.

The operative terms of the statute are as follows:

> (2) Period of coverage.
>
> The coverage must extend for at least the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following:
>
> > . . . (D) . . . . The date on which the qualified beneficiary first becomes, after the date of the election —
> >
> > > (i) covered under any other group health plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary. . . .

29 U.S.C. § 1162(2)(D).

As authority to establish the "natural reading" of a term or phrase in "legal and general usage" the Court relies on contemporaneous dictionaries. *See, e.g., Gustafson v. Alloyd Co.*, 513 U.S. 561, 575-76 (1995); *Reves v. Ernst & Young*, 507 U.S. 170, 177-78 (1993); *Estate of Cowart v. Nicklos Drilling Co.*, 505 U.S. at 477; *Gollust v. Mendell*, 501 U.S. 115, 124 (1991); *Mallard v. U.S. Dist. Court for the Southern Dist. of Iowa*, 490 U.S. 296, 301 (1989). Both legal and non-legal dictionaries define

"after" in such terms as "Later, succeeding, subsequent to, inferior in point of time. . . . Subsequent in time to." *Black's Law Dictionary*, 57 (5th Ed. 1979) (*citing*, *Cheney v. National Surety Corp.*, 10 N.Y.S. 2d 706 (App. Div. 4th 1939) (construing the word "after" in the phrase "after an accounting" as meaning "subsequent in time to"). *See also Webster's New Collegiate Dictionary*, 21 (1979).[6]

Thus, the phrase "after the date of the election — covered . . ." in the COBRA statute at issue can only be read as meaning "covered subsequent in time to the date of the election" and cannot colorably be read as meaning "covered at any time before or subsequent to the date of election."

This same inescapable meaning is obtained when one considers the term "after the date of the election" in the context of the phrase "The date on which the qualified beneficiary first becomes . . . covered. . . ." In both legal and general usage the word "become" means:

> to pass from one state to another; to enter into some state or condition, by a change from another state or condition, or by assuming or receiving new properties or qualities, additional matter, or a new character;

Webster's New Universal Unabridged Dictionary, 164 (Deluxe 2nd Ed. 1979). *Accord*, *Hislop v. County of Lincoln*, 437 P.2d 847, 850 (Or. 1968) (In Banc) (*citing*, *Webster's New International Dictionary*).

"Becomes" requires a change from one status to another. Courts have adhered to this definition, for example, in interpreting

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6. When words have more than one dictionary definition, the Court considers the context to determine which definition to apply. *Ardestani*, 502 U.S. at 135.

disability policies which provide for disability retirement benefits to an employee who "becomes . . . disabled after [a set date]." *Farr v. Fruehauf Corp.*, 258 N.W. 2d 821, 823 (Neb. 1977). Under this policy, an employee with a pre-existing injury would not "become disabled" after the effective date of a disability policy even though his doctor did not realize until after the effective date that the employee's prior condition rendered him disabled, where there was no actual change in his condition. *Farr v. Fruehauf Corp.*, 258 N.W. 2d at 823-24 (*citing*, *Hilsop*). Similarly, Mr. Geissal could not "first become . . . covered" after the date of the qualifying event because his coverage status did not change after the date of the qualifying event. Accordingly, as required by the plain meaning of the statute Mr. Geissal should have received the benefit of COBRA continuation coverage.

In addition, the fact that the word "becomes" is bolstered by the word "first" plainly shows that Congress had a date certain "after the date of the election" in mind. *See Nunn v. Washington*, 788 F.2d 617, 618-19 and n.2 (9th Cir. 1986) (words "first became due" in 11 U.S.C. § 523(a)(8)(A) suggests that Congress meant a specific date.). As used in COBRA "first" means "initially" *Black's Law Dictionary*, 371 (5th ed.) — suggesting that Congress meant continuation coverage to terminate on the specific initial date that the qualified beneficiary obtains new coverage under another group health plan "after the date of election".

Yet another significant aspect of the statutory language in question is the repeated use of the definite article in connection with the word "date." The use of the definite article in phrase: "The date . . . after the date of the election. . . ." implies that each date is "definite" and "specified by context or circumstance." *Webster's New Collegiate Dictionary*, 1199. Thus "The date" is not before, nor on the same day as the election, but must be subsequent to it. Congress's use of the words "becomes . . . covered" in this context requires that the coverage must start on a definite day ("The date . . . after") subsequent to a definite day ("the date of the election") for the exception to be operational, and not before this specific day.

The Court has been careful to respect specific temporal distinctions in statutes like the one at issue, even where the results are harsh — which they are plainly not in this case. For example, in *United States v. Locke*, the Court was called on to consider whether the owner of a mining claim on federal land abandoned the claim by filing a notice of intention to hold the claim *on* December 31st, when a statute required this document to be filed "prior to December 31 of each year." 471 U.S. 84, 88 & 93 (1985). The Court held, with respect to the statutorily specified date:

> . . . a literal reading of Congress' words is generally the only proper reading of those words. To attempt to decide whether some date other than the one set out in the statute is the date actually land abandoned the claim by filing a notice of intention to hold the claim with state officials 'intended' by Congress is to set sail on an aimless journey. . . .

471 U.S. at 93. Even though a literal reading of the statute would plainly lead a mining business to unintentionally lose a claim that had been held for over 20 years, the Court found:

> The phrase "prior to" may be clumsy, but its meaning is clear. Under these circumstances, we are obligated to apply the "prior to December 31" language by its terms. . . . We cannot press statutory construction "to the point of disingenuous evasion."

471 U.S. at 96 (*quoting*, *Moore Ice Cream Co. v. Rose*, 289 U.S. 373, 379 (1933) (Cardozo, J.)). *See also Milwaukee Brewery Workers' Pension Plan v. Jos. Schlitz Brewing*, 513 U.S. 414, 424-25 (1995) (Provision required calculation of payments "as if the 'first payment' was made not on the last day of the withdrawal year, but on the 'first day' of the next year. . . . This choice of time (a year and a day) would be an odd way to signal that one is to treat the first payment as if it occurred at the end of a cycle.").

The Seventh Circuit correctly describes the meaning of these terms and phrases in their context in *Lutheran Hospital*:

> The statute clearly provides that the employee's right to continuation coverage terminates only when he or she *first* becomes, *after* the election date, *covered* by any other group health plan. The statute does not say that an employee is ineligible for continuation coverage if he or she is covered by a preexisting group health plan. Nor does the statute say that a beneficiary's rights terminate when he or she becomes eligible for additional or alternative group health insurance. Therefore, an employee loses the right to continuation coverage only if he or she chooses after the election date to accept coverage under another group health plan.

51 F.3d at 1312 (emphasis in original).

Respondent, and several courts of appeal, ask the Court to read the statute as if the words "The date on which," "first becomes," and "after the date of the election" simply were not in the statute. Doing this would violate a rule of statutory construction which must be admitted to the college of cardinal canons because it is a necessary correlate to the "natural reading" rule: a statute must be interpreted, wherever possible, to give effect to all of its provisions, so that no part will be inoperative or superfluous. *United States v. Menasche*, 348 U.S. 528, 538-39 (1955) ("The cardinal principle of statutory construction is to save and not to destroy. It is our duty 'to give effect to every clause and word of a statute. . . .' ") (citations omitted). *See also Milwaukee Brewery Workers' Pension Plan v. Jos. Schlitz Brewing*, 513 U.S. at 424; *Plaut v. Spendthrift Farm*, 514 U.S. 211, 217 (1995); *Connecticut Nat'l Bank*, 503 U.S. at 254 (*quoting*, *Sturges v. Crownshield*, 17 U.S. (4 Wheat.) 122, 202 (1819)).

IV.

THE CONCLUSIONS DERIVED FROM THE UNAMBIGUOUS TERMS OF THE STATUTE ARE VERIFIED WHEN THE STATUTE IS READ THROUGH THE LENSES OF OTHER ESTABLISHED CANONS OF STATUTORY CONSTRUCTION.

A. Structure of the Underlying Statute

To bolster and verify the conclusion suggested by the natural reading of a statute, courts sometimes seek guidance from "the structure of the statute." *Estate of Cowart v. Nicklos Drilling Co.*, 505 U.S. at 477. In this case, the provision at issue is an amendment to the Employee Retirement Income Security Act, "an enormously complex and detailed statute that resolved innumerable disputes between powerful competing interests." *Mertens v. Hewitt Assoc.*, 508 U.S. 248, 262 (1993). The assumption that Congress's choice of words was mistaken "is rendered especially suspect upon close consideration of ERISA's interlocking, interrelated, and interdependent remedial scheme, which is in turn part of a 'comprehensive and reticulated statute.' " *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985) (*quoting*, *Nachman Corp. v. Pension Benefit Guarantee Corp.*, 446 U.S. 359, 361 (1985)). It is therefore "especially true" in cases involving ERISA that statutory text bearing on specific issues should not be allowed to yield to general notions of overall statutory purposes. *Mertens*, 508 U.S. at 261-62.

B. Use of Terms Elsewhere in Statute

"[I]dentical words used in different parts of the same act are intended to have the same meaning." *Gustafson v. Alloyd Co.*, 513 U.S. 561, 570 (*quoting*, *Department of Revenue of Oregon v. ACF Indust.*, 510 U.S. 332, 342 (1994)). *See also National Credit Union Administration v. First National Bank & Trust*, 1998 WL 75036, 13 (U.S. February 25, 1998) ("similar language within the

same section of a statute must be accorded a consistent meaning"). Accordingly, the Court should consider whether the words or phrases in question can "bear the meaning placed on it by [respondents]" when they appear elsewhere in the statute in question; *Estate of Cowart v. Nicklos Drilling Co.*, 505 U.S. at 478.

The phrase "after the date of" — which Respondents wish to construe into vapor — appears seven times in subsection 1162(2) alone. The absence of this phrase would turn the entire subsection into an ungrammatical and nonsensical nightmare. The Court would be left to interpret phrases like "the date which is 18 months the qualifying event" 1162(2)(A)(i) (modified by removing word "after") and "36 months the death of the covered employee." 1162(2)(A)(iii) (modified by removing word "after"). Congress presumably did not wish to restrict COBRA to layoffs which take 18 months to implement, or to the families of covered employees who take 36 months to die. Similarly, the operative phrases in this case are essential to interpreting other sections of COBRA, such as the notice provisions. *See, e.g., Branch v. G. Bernd Co.*, 764 F. Supp. 1527, 1536 & 1541 (M.D. Ga. 1991) (interpreting the phrases "*at least* 60 days duration" in 29 U.S.C. § 1165(1)(B) and "ends *not earlier than* 60 days after [the date of]" in 29 U.S.C. § 1165(1)(C) as "setting a floor below which the [COBRA] election period may not fall." (emphasis added)), *aff'd*, 955 F.2d 1574 (11th Cir. 1992). It is obvious that Congress desired that these phrases be meaningful, and the Court should be wary of any reading that would render them meaningless. *See West Virginia Univ. Hospitals, Inc. v. Casey*, 499 U.S. 83, 101 (1991) ("[I]t is our role to make sense rather than nonsense out of the corpus juris.") (Scalia, J.).

C. Mandatory Language in Statute

There are other significant indications in the text that COBRA health insurance coverage is to be provided following a qualifying event wherever possible, and that exceptions are to be read

restrictively: Section 1162(2) employs mandatory language which attempts to resolve any doubts about the continuation of coverage in favor of the beneficiary:

> The coverage *must* extend *for at least* the period beginning on the date of the qualifying event *and ending not earlier than* the earliest of the following:

29 U.S.C. § 1162(2) (emphasis added). Imperative language like "for at least," "not earlier than" and "must" are used when a legislature means "to impose a positive and absolute duty and not merely to give a discretionary power." *Minor v. The Mechanics Bank of Alexandria*, 26 U.S. (1 Peters) 46, 64 (1828) (Story, J.). *See also Mason v. Fearson*, 50 U.S. (9 Howard) 248, 259 (1850) (contrasting "may" — as possibly conferring discretionary power — with "must"); *Branch v. G. Bernd Co.*, 764 F. Supp. at 1536 & 1541. This language eliminates judicial discretion to "construe away" the statutory mandate. *Chevron U.S.A. v. National Resources Defense Council Inc.*, 467 U.S. 837, 842-43 (1984).

D. Exceptions are to be Strictly Construed

It is also notable that the language Respondents wish the Court to read contrary to its plain meaning is a "proviso" or "exception." The language of paragraph 1162(2)(D) is a proviso/exception because it restricts the operative effect of subsection 1162(2) by limiting the "the period" during which "coverage must extend." *Cf. Commerce Bank of Kansas City, N.A. v. Missouri Div. of Fin.*, 762 S.W. 2d 431, 434 (Mo. App. 1988) (a "proviso" excepts, limits, restricts, or qualifies the general terms of a statute "or [excludes] from the scope of the statute that which otherwise would be within its terms." (citation omitted)); *Murphy v. Nilsen*, 19 Or. App. 292, 297, 527 P.2d 736, 738 (Or. App. 1974). When in doubt, such provisions are to be construed in favor of the general operation of the statute, which is assumed to express the overall legislative purpose. *See, e.g., A.H. Phillips, Inc. v. Walling*, 324

U.S. 490, 493 (1945). Where there is an express exception, it comprises the only limitation on the operation of the statute, and no other exceptions will be implied. *Andrus v. Glover Const. Co.*, 446 U.S. 608, 616-17 (1980). While this argument is normally itself compelling, it is particularly so in this case given that the exception imposes a limitation on the imperative language in section 1162(2).

V.

THE COURT SHOULD ONLY OVERTURN AN UNAMBIGUOUS STATUTE IF IT YIELDS AN "ABSURD RESULT."

There is only one uncontroversial exception to the "plain meaning" rule:

> Where the plain language of the statute would lead to "patently absurd consequences," *United States v. Brown*, 333 U.S. 18, 27 (1948), that "Congress could not *possibly* have intended," *FBI v. Abramson*, 456 U.S. 615, 640 (1982) (O'Connor, J., dissenting) (emphasis added), we need not apply the language in such a fashion. When used in a proper manner, this narrow exception to our normal rule of statutory construction does not intrude upon the lawmaking powers of Congress, but rather demonstrates a respect for the coequal Legislative Branch, which we assume would not act in an absurd way.

Public Citizen v. United States Dept. of Justice, 491 U.S. 440, 470 (1989) (Kennedy, J. concurring) (emphasis in original). However, Justice Kennedy cautions:

> The exception remains a legitimate tool of the judiciary, however, only so long as the Court acts with self-discipline by limiting the exception to

> situations where the result of applying the plain language would be, in the genuine sense, absurd, *i.e.* where it is quite impossible that Congress could have intended the result . . . , and where the alleged absurdity is obvious to most anyone.

Id. at 470-71. Examples of absurd results might include a law allowing the prosecution of a police officer arresting a mail carrier for obstructing the mails, or applying a medieval law against drawing blood in the streets against a paramedic aiding an accident victim.[7] *Id.* However, applying the doctrine in recognition of something less than patent absurdity:

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7. In rare instances, courts justify overturning what might appear to be a natural statutory reading of a piece of legislation on the basis that it is purely the result of a scrivener's error or "slip of the pen" of the draftsperson. *See* Breyer, "On the Uses of Legislative History in Interpreting Statutes," 65 So. Cal. L. Rev. 845, 850-51 (1992). This type of judicial correction is more controversial than the exception based on absurdity: when there are plausible reasons for a statutory distinction, it is far more likely that the distinction was based on a policy choice — and that judicial interference with it treads on the constitutional prerogatives of the legislature. *See City of Chicago v. Environmental Defense Fund*, 511 U.S. 328, 339 (1994) ("It is not unusual for legislation to contain diverse purposes that must be reconciled and the most reliable guide for that task is the enacted text.") "The facile attribution of congressional 'forgetfulness' cannot justify such a usurpation." *West Virginia Hospitals*, 499 U.S. at 101. Consequently, the quantum of evidence required to prove a scrivener's error is as high as it would be without the allegation, *see, e.g., United States v. Locke*, 471 U.S. at 95 ("But the fact that Congress might have acted with greater clarity or foresight does not give the courts a *carte blanche* to achieve that which Congress is perceived to have failed to do."): A more textual approach would require "a scrivener's error *producing* an absurd result," *Union Bank*, 502 U.S. at 163 (emphasis added), while a more historical approach would require a "conclusive statement" that

(Cont'd)

> . . . creates too great a risk that the Court is exercising its own "WILL instead of JUDGMENT," with the consequence of "substitute[ng] [its own] pleasure to that of the legislative body."

Id. (*quoting*, The Federalist No. 78, p. 469 (C. Rossiter, ed. 1961) (A. Hamilton)).

VI.

A STRAIGHTFORWARD READING OF THE STATUTE DOES NOT YIELD AN "ABSURD RESULT."

As the Seventh Circuit recognized, there is absolutely nothing remotely absurd about the result of reading the statute at issue here in a straightforward manner:

> The statutory distinction between preexisting and after-acquired health care coverage is reasonable and facilitates the preservation of the beneficiary's health care status quo. The plain language of the statute dictates that an individual only loses COBRA

(Cont'd)
would "undermine the ordinary understanding of the phrase." *Ardestani*, 502 U.S. at 136 & Section 8, *supra*. A bare allegation of a drafting error does nothing to aid the analysis.

In this case, there is nothing in the text of the statute or the legislative history of the specific language in question that remotely suggests a drafting error. Congress has revisited and revised the subsection in question numerous times since it enacted the words "after the date of the election," and has left these words alone even while the courts of appeal have applied their varying interpretations. Repeated congressional re-enactment of the controverted terms of a disputed statute tend to dispel any assertion that the terms were the product of a scrivener's error, or that Congress's enacted an absurd provision. *See Mallard v. U.S. Dist. Court for the Southern Dist. of Iowa*, 490 U.S. at 306-07.

> eligibility if he or she chooses to accept alternative group health insurance after the qualifying event. By the terms of the statute, the individual has the choice whether to preserve the status quo and continue the prior level of coverage under COBRA or accept alternative coverage and discontinue COBRA. In either case . . . the individual is never forced to accept a lower level of health care coverage than he or she received as an employee before the qualifying event. If on the other hand the language of the statute is ignored and preexisting double coverage disqualifies one from COBRA continuation coverage, upon termination an employee's status quo is not preserved and the level of coverage automatically drops to the level provided by the preexisting coverage as a beneficiary of the spouse's employer's plan. . . .

Lutheran Hospital, 51 F.3d at 1312.

The Eighth Circuit, however chose to ignore the plain meaning of the statutory language based on an erroneous interpretation of statements in Congressional committee reports. The Court of Appeals found that Congress was motivated primarily by a desire to ensure that terminated employees are provided only "bare-bones" coverage and not the preservation of the employee's health insurance status quo. *Geissal*, 114 F.3d at 1463. These contentions are refuted in detail below. Nonetheless, whatever one can divine of Congressional "intent" from such sources, it cannot be said that "Congress could not possibly have intended the result" of preserving the health insurance status quo of an employee who experiences a qualifying event, or that preserving this option for an employee would be "an absurdity that would be obvious to almost anyone." A Congressional intent to preserve the status quo is easily derived from the terms of the statute itself. *See Lutheran Hospital*, 51 F.3d at 1313. A qualified individual must *choose* to pay for the additional coverage that COBRA provides. 51 F.3d at 1312. This choice, for certain individuals — such as the Petitioner's

family who faced the possibility of accepting certain death, or facing financial ruin to pay for chemotherapy — may be far from "absurd." Anticipating such circumstances was not an "absurd" thing for Congress to do.

In contrast to the reasonable result one gets through a plain reading of the statute, the consequences of the interpretation invented by the Eleventh Circuit and adopted by the Eighth leads the courts to morass of questions, paradox and absurdity in trying to determine how to calculate a significant gap in coverage: "Does the magnitude of personal liability sufficient to constitute a gap depend on the ability of the individual to pay or on the overall scale of the medical expenses?" *Lutheran Hosp.*, 51 F.3d at 1314. Should the determination of whether there is a "gap" be made *ex ante* — at the peril of the family who decided to rely on COBRA for secondary coverage, or *post hoc* after the employer has already made a determination about whether termination of COBRA benefits is warranted? *Geissal*, 114 F.3d at 1464-65. If *ex ante*, as the Eighth Circuit held:

> [h]ow much information about the patient's physical and financial condition is the court to presume of the employer in making this after-the-fact comparison? Is the court to apply an objective or subjective standard, i.e. is it what the employer knew or what he reasonably should have known? . . . Must an employer utilize an actuary or medical expert to determine the likely effect of policy differences given the patient's physical condition at the time of the qualifying event?

51 F.3d at 1315. As the Seventh Circuit observed:

> This whole morass can be avoided by honoring the language of the statute and the decision of the insured as to how much coverage is adequate to her own situation.

VII.

ABSENT ABSURDITY, THE COURT SHOULD NOT OVERTURN THE STATUTE'S SPECIFIC PROVISIONS ON THE BASIS OF GENERALIZED NOTIONS OF STATUTORY INTENT.

Some cases suggest that a contrary legislative intent that is "clearly expressed" may overcome the "strong presumption" that the language of the statute expresses congressional intent in certain "rare and exceptional" cases. *Ardestani*, 502 U.S. at 136. Those cases which acknowledge this possibility would require "a conclusive statement" in an authoritative text about the meaning of the specific phrase in question that would "undermine the ordinary understanding of the phrase." *Ardestani*, 502 U.S. at 136. *See also Conroy v. Aniskoff*, 507 U.S. 511, 518 n.12 (1993) (Stevens, J.) (Court has no duty to enforce statute as written even "if fully convinced that every Member of the enacting Congress, as well as the President who signed the Act, intended a different result."). *But cf. Hubbard v. United States*, 514 U.S. at 708 (Stevens, J.) ("Courts should not rely on inconclusive statutory history as a basis for refusing to give effect to the plain language of an Act of Congress. . . .") Even this line of cases has become increasingly ambivalent about whether legislative history can ever be used in overturning the presumptive "plain meaning" definition of statutory terms,[8] or whether the inquiry is limited to "the text of

8. Some cases still explore the legislative history notwithstanding a finding that the meaning of a statute is clearly and unambiguously expressed in the text. These cases explain these discussions as efforts to "confirm" the intention expressed in the text, *Thunder Basin Coal Co. v. Reich*, 510 U.S. 200, 209 (1994), "confirm" that Congress would not have regarded the result of a natural reading as "absurd or illogical," *Conroy v. Aniskoff*, 507 U.S. at 516, or are set forth out of indulgence for a Court of Appeals that found historical arguments persuasive. *See Curtiss-Wright Corp. v.*

(Cont'd)

the act of Congress surrounding the word at issue, or the texts of other related Congressional Acts." *Id.* at 701 (*citing*, *Rowland v. California Men's Colony, Unit II Men's Advisory Council*, 506 U.S. 194, 199 (1993)). *Cf.* 514 U.S. at 702-03 ("Although the historical evolution of a statute — based on decisions by the entire Congress — should not be discounted for the reasons that may undermine the significance of excerpts from congressional debates and committee reports, (footnote omitted) a historical analysis normally provides less guidance to a statute's meaning than its final text. In the ordinary case, absent any 'indication that doing so would frustrate Congress's clear intention, or yield patent absurdity, our obligation is to apply the statute as Congress wrote it.' " (*quoting*, *BFP v. Resolution Trust Corporation*, 511 U.S. 531, 570 (1994) (Souter, J. dissenting))).

In those increasingly unusual cases in which the Court resorts to a detailed discussion of legislative history, the Court's precedent does not allow a departure from the dictates of specific statutory language because "the legislative goals underlying the statute," "the clearly stated objective of the [statute]" or the "broad purposes of [the statute]" . . . "would be served" by a different "functional" interpretation. *Ardestani*, 502 U.S. at 137-38. "[V]ague notions of a statute's 'basic purpose' are . . . inadequate to overcome the words of its text regarding the *specific* issue under consideration." *Mertens v. Hewitt Associates*, 508 U.S. 248, 261-62 (1993) (Scalia, J.) (emphasis in original) (*citing*, *Pension Benefit Guaranty Corporation v. LTV Corp.*, 496 U.S. 633, 646-47 (1990)).[9]

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Schoonejongen, 514 U.S. 73, 81 (1995). Such frolics, however useful when the textual meaning of a statute is truly in doubt, *see Connecticut National Bank*, 503 U.S. at 255, are now otherwise indulged only reluctantly, *Curtiss-Wright Corp.*, 514 U.S. at 80-81 and usually not without criticism. *See, e.g.*, *Thunder Basin Coal Co.*, 510 U.S. at 219 (Scalia, J. concurring); *Conroy v. Aniskoff*, 507 U.S. at 518-19 (Scalia J. concurring).

9. Some rather venerable contrary authority has not been

(Cont'd)

VIII.

AN HISTOROCENTRIC ANALYSIS WOULD NOT OVERTURN THE SPECIFIC TERMS OF A STATUTE UNLESS ADHERENCE TO THE STATUTORY TERMS WOULD "THWART THE OBVIOUS PURPOSES OF THE ACT."

The burden to overcome the strong presumption in favor of a straightforward reading of the statute clearly lies with the proponent of the "special rule." *Union Bank v. Wolas*, 502 U.S. at 156.[10] Precedents that stand entirely outside of the modern reassertion by the Court of what is sometimes referred to as "literalism" or "textualism" demonstrate that it has always been extremely difficult for a party to overcome the specific terms of statutory language

(Cont'd)
explicitly overruled, *see Church of the Holy Trinity v. United States*, 143 U.S. 457, 459 (1892) ("[A] thing may be within the letter of the statute and yet not within the statute, because it is not within its spirit, nor within the intention of the makers."), although soundly criticized. *See Public Citizen v. United States Dept. of Justice*, 491 U.S. at 472-74 (Kennedy, J. concurring). To the extent that *Church of Holy Trinity* and its progeny are inconsistent with constitutionally sound doctrine, and the repeated modern precedents of this Court, *see, e.g., Mertens v. Hewitt Associates*, 508 U.S. at 261-62; *Ardestani*, 502 U.S. at 137-38, the Court should not hesitate to dispense with them. Indeed, there probably would have been far less confusion in the lower courts in the case at bar, and other cases interpreting the statute at issue, if this Court applied the principal of *stare decisis* as consistently in the context of its announced rules of statutory interpretation as it does with other law.

10. Another reason that Respondent has the burden to prove that their interpretation of the statute should be adopted is that the statutory language at issue is an exception to the general operation of section 1162(2). *United States v. First City Nat. Bank of Houston*, 386 U.S. 361, 366 (1967) (One who claims the benefit of an exception from the prohibition of a statute has the burden of proving that his claim comes within the exception.).

with references to legislative history discussing the broad purposes of a statute. For example, in *Mansell v. Mansell*, 490 U.S. 581 (1989), Justice Marshall engages in a rich discussion of the legislative history — albeit primarily in footnotes — in a case where the court was called on to interpret the "plain and precise statutory language," 490 U.S. at 592, of the Former Spouse's Protection Act. *Id.* at 590 n.10; 591 n.11-n.13; 592 n.14; 593 n.15-n.18; 594 n.19. Nevertheless, Justice Marshall pointed out that in the face of that language, the Respondent:

> faces a daunting standard. She cannot prevail without clear evidence that reading the language literally would thwart the obvious purposes of the act.

490 U.S. at 592 (citation omitted). The Court found, just like in this case, that the legislative history "does not indicate the reason" that Congress chose to make the specific distinction at issue in that case in the way it did. *Id.*

> But the absence of legislative history on this decision is immaterial in light of the plain and precise language of the statute; Congress is not required to build a record in the legislative history to defend its policy choices.

Id.

"Because of the absence of evidence of specific intent in the legislative history" the respondent in *Mansell*, like the respondent in this case, was forced to resort "to arguments about the broad purposes of the Act." *Id.* Justice Marshall found this reliance to be misplaced because, at this general level, as is the case with almost all federal statutes, "there are statements [in the legislative history] that both contradict and support her arguments." *Id.* Justice Marshall concludes:

> Given Congress' mixed purposes, the legislative history does not clearly support Mrs. Mansell's view that giving effect to the plain and precise language of the statute would thwart the obvious purposes of the Act. We realize that reading the statute literally may inflict economic harm on many former spouses. But we decline to misread the statute in order to reach a sympathetic result when such a reading requires us to do violence to the plain language of the statute. . . . Congress chose the language that requires us to decide as we do, and Congress is free to change it.

490 U.S. at 594.

IX.

ANALYSIS OF THE LEGISLATIVE HISTORY SHOWS THAT THERE IS NO "CONCLUSIVE STATEMENT" THAT UNDERMINES THE ORDINARY MEANING OF THE LAW AND THAT ADHERENCE TO THE SPECIFIC TERMS OF THE STATUTE WOULD NOT "THWART THE OBVIOUS PURPOSES OF THE ACT."

The legislative history of the continuation of coverage provisions in COBRA is very sparse and generalized COBRA was a massive piece of legislation which was rushed through Congress in order to reconcile the nation's budget. Although the rationale for continuation coverage had been circulating in Washington for quite some time — that something should be done to help individuals who lose their health coverage just because they lose their jobs — there were no formal hearings or detailed reports on what ultimately became the language at issue in this case. As a result, most of what one finds when attempting to discern the legislative intent behind various statutory passages from

extrinsic materials are pontifications by Congressional committees in after-the-fact reports.[11]

In this case, the Eighth and Eleventh Circuits place principal reliance on a phrase in a House Committee Report describing the general purposes of the first version of COBRA:

> The Committee is concerned with reports of the growing number of Americans without any health insurance coverage. . . .

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11. This lack of legislative history is lamented in several scholarly articles, most particularly in an article which appeared in the *Journal of Contemporary Health Law and Policy*, "COBRA: An Incremental Approach to National Health Insurance", 5 J. Contemp. Health L. & Pol'y, 141 (April, 1989). In the course of examining the place of COBRA in national health policy, author Thomas H. Somers lamented the manner in which continuation coverage became law. Under a heading entitled "COBRA: A 'Middle of the Night" Enactment?", he noted that Congress enacted COBRA "without deliberation and in the process of amending three distinct statutes", causing:

> a fair amount of regulatory confusion and bureaucratic tension. . . . Absent solid statutory or regulatory guidance for a legislative history that unravels COBRA's complexity, one commentator has asked whether COBRA was rationally considered, a "middle of the night" addition to the Budget Reconciliation Act. [Footnote omitted] Indeed some might argue that COBRA is symptomatic of Congress' growing inclination to delegate unlimited legislative authority to the other branches of government. The absence of legislative direction, of course, is where federal agencies and, inevitably, the courts are often called upon to divine legislative will.

The author then intones, presciently, "we should expect much of the same in COBRA's future".

See Geissal, 114 F.3d at 1463, *and National Companies*, 929 F.2d at 1567 (*citing*, H.R. Rep. No. 99-241, pt. 1, at 44 (1995), *reprinted in*, 1986 U.S. Code Cong. & Admin. News 579, 622). Focusing on the word "any" in this phrase, these courts derived from this statement the principle that "Congress enacted COBRA [solely] because it was concerned about the fate of individuals who, after losing coverage under the employer's ERISA plan, had no group coverage at all." *National Companies*, 929 F.2d at 1569.

This murky phrase is a slender reed from which to dangle the argument that Congress's intent differed from what it expressed in the plain language of the statute. *See National Credit Union Administration*, 1998 WL 75036, 14 n.10. First of all, it is not the only broad statement of Congressional intent in the Committee report — or even in that sentence of the report. The statement continues that the Committee is also concerned about:

> the decreasing willingness of our Nation's hospitals to provide care to those who cannot afford to pay.

H.R. Rep. No. 99-241, pt. 1, at 44 (1995), *reprinted in*, 1986 U.S. Code Cong. & Admin. News 579, 622. The Committee also discusses its intent that:

> The coverage provided . . . would be identical in scope to the coverage provided under the group plan to similarly situated individuals in the group."

Id.

This language does not suggest that Congress was concerned solely with the subclass of persons without *any* health insurance, but also with the broader class of individuals who might not be able to "afford to pay" for hospital care as a result of the loss of their job, or another qualifying event. Certainly hospitals might not treat patients without any health insurance, but they might be

just as unwilling to treat underinsured patients in need of expensive treatments, such as Mr. Geissal, or the patients in those district court cases which terminated benefits because the employer was not on notice of the full extent of the employee's needs "at the time of election." *See, e.g., Daniel v. Master Health Plan, Inc.*, 864 F. Supp. at 1406 ($800,000 shortfall); *Taylor v. Kawneer Co. Comprehensive Medical Expense Plan*, 898 F. Supp. 667 ($121,000 patient liability incident to an infant's premature birth); *Liberty Life Assurance v. Toys "R" Us, Inc.*, 901 F. Supp. at 564 ($153,000 in bills related to an autologous bone marrow transplant). As the Seventh Circuit observed:

> The fact that Congress may have been motivated by the plight of a smaller sub-class — people without any health insurance — does not mean that in remedying the situation they necessarily limited relief to that subclass rather than the larger group, including Mary Isch, who lose jobs and all or part of their insurance.

Lutheran Hospital, 51 F.3d at 1313 n.5.

Similar observations could be made about the Committee's statements that the coverage provided should be "identical in scope" to that of "similarly situated individuals in the group." Each of the patients in the cases listed above would have been far better off had they not had a "qualifying event" before they experienced a medical crisis. Other similarly situated individuals in the group would benefit from the dual coverage they chose as members of the group, but the plaintiffs in these cases ultimately found that they could not benefit from the continuation coverage that they both chose and paid for. There is nothing "identical in scope" about this coverage.

Because they assume that it is permissible to interpret this statute in terms of broad goals expressed in the legislative history, various courts appear to have believed that they had to choose

between the broad goals expressed in this vague legislative pronouncement to determine which ones Congress "intended" to be serving — providing health insurance to those without "any" or preserving the "status quo?" The legislative history answer is probably all of the above — the most inclusive characterization being the most accurate. Thus, it would be perfectly consistent with the "broad purposes" of the act to "interpret" section 1162(2) to allow the widest range of coverage possible — were it permissible to "interpret" a statute in this fashion at all.

But these courts had it all wrong: because the statutory language is clear, the role of the courts, if any, should not have been to explore legislative intent ab initio, but simply to determine whether "the language literally would thwart the obvious purposes of the act." *Mansell*, 490 U.S. at 592 (citation omitted), or put another way, whether there is "a conclusive statement" in another authoritative text about the meaning of the specific phrase in question that would "undermine the ordinary understanding of the phrase." *Ardestani*, 502 U.S. at 136. There is no legislative history that precisely discusses the meaning of the phrase in question, and the minimal general discussion about the overall legislative purposes of COBRA contains statements "which both contradict and support [respondent's] arguments."[12] *Mansell*, 490 U.S. at 592. There is no reason for consideration of legislative history to go any farther than this.

Perhaps aware of the significance of the contradictions in the original legislative documents concerning COBRA, some courts

12. Even if it could be proved that Congress made a statutory change to achieve certain broad goals, it is for Congress to decide how to address the problem. "The fact that Congress may not have foreseen all of the consequences of a statutory enactment is not a sufficient reason for refusing to give effect to its plain meaning." *Union Bank v. Wolas*, 502 U.S. at 158 (*citing, Toibb v. Radloff*, 501 U.S. 157, 164 (1991)). "Whether Congress has wisely balanced the sometimes conflicting policies underlying [the statute] is not a question that [the Court is] authorized to decide." *Union Bank v. Wolas*, 502 U.S. at 162.

have resorted to statements in committee reports on amendments to COBRA which allegedly discuss "the original intent of the health care continuation rules." *See, e.g.*, H.R. Rep. No. 101-247, 101st Cong., 1st Sess., *reprinted in* 1989 U.S. Code Cong. & Admin. News 1906, 1943. However, these statements are equally broad. For example, discussion of the 1989 amendment describes the intent as:

> to reduce the extent to which certain events, such as the loss of one's job, could create a significant gap in health coverage.

Id. It then goes on to say:

> If a qualified beneficiary is covered under another plan that excludes coverage for a preexisting condition, he or she is at risk during the period of exclusion.

Id. This language both posits an example of the type of problem the Committee felt needed clarification, and identifies the precise problem the amendment would clarify. However, there is no indication at all that in specifying this problem, the Committee limited its own concept of a "significant gap" to circumstances involving pre-existing conditions. In fact, the language of the report defines it much more broadly:

> If the qualified beneficiary is willing to elect health insurance continuation coverage from a previous employer as well, that is a strong indication that the new employer has left a significant gap in coverage.

Id. Thus, the final, very particular 1989 amendment to the statutory clause appears to have been intended to rectify the problem of disqualifying group coverage acquired after the date of election, in which the participant would not be eligible for the benefits which he or she most needed, *i.e.*, for a pre-existing illness.

Congress left the statutory language we are concerned with in this case alone — even though they had a clear opportunity to change or eliminate it. There was no indication that "the language literally would thwart the obvious purposes of the act," *Mansell*, 490 U.S. at 592 (citation omitted), and no "conclusive statement" in the legislative history that "undermine[s] the ordinary understanding" of the statutory language *Ardestani*, 502 U.S. at 136. Moreover, even if the committee report contained such statements, the Court would not give them effect without a corresponding change in the statutory language because the views of a subsequent Congress form a "hazardous basis for inferring the intent of an earlier" one. *Pension Benefit Guaranty Corp. v. The LTV Corp.*, 496 U.S. 633, 650 (1990) (*quoting, United States v. Price*, 361 U.S. 304, 313 (1960)). *See also Waterman Steamship Corp. v. United States*, 381 U.S. 252, 269 (1965); *United States v. Wise*, 370 U.S. 405, 411 (1962)).

One final argument in Respondent's opposition to Certiorari probably must be briefly addressed. Respondents assert that the statute in question must not have a "plain meaning" because some appellate judges have interpreted it in a manner that contradicts the interpretation urged by Petitioner. *Respondent's Brief in Opposition*, at 4. This is the height of circular logic, and a quite dangerous example of it. If this argument were accepted, then no statute — no matter how clear — could be interpreted by its plain terms so long as one judge could be found to disagree with the plain interpretation. It is notable that in most of the above listed cases which this court has held that the "plain meaning" of a statute governs, some lower court judge, or a Justice on this Court, has found a basis to question or disagree with the Court's interpretation of the statute's plain meaning. Respondent's argument would render the United States statutes a virtual nullity, and cause the bar to replace their volumes of the United States Code with copies of congressional committee reports. Like statements by congressmen and committees, statements by courts and judges after the language of an act in question was passed "are not a reliable indicator of what Congress intended when it passed the law, assuming

extratextual sources are to any extent reliable for this purpose." *Gustafson v. Alloyd Co., Inc.*, 513 U.S. at 579.

X.

PUBLIC POLICY CONSIDERATIONS SUPPORT THE INTERPRETATION URGED BY PETITIONERS.

Some authority exists for the proposition that a court may look to considerations of public policy where a statute is unclear and or silent about an important issue that faces the court. There is nothing unclear about the statute at issue in this case. Nevertheless, several courts of appeals — including the Eighth Circuit — have treated the statute as if it was unclear to arrive at a result that contradicts the plain meaning of the statute.

Because the language of the statute is clear, we believe that a detailed discussion of public policy is unnecessary. Nevertheless, mindful that some courts of appeal seem to have put such great stock in these arguments that they felt compelled to dispense with the text, Petitioner would be remiss if she did not mention the strong public policy arguments that support her position.

There are many good reasons why Congress would not want to see citizens lose one health care policy because of a loss of employment (or other enumerated causes), even if they have other coverage. These reasons are either clearly expressed, or effectively implied in the above referenced legislative documents: Congress did not want families to go without hospital treatment because, as a consequence of termination, they no longer have adequate insurance, as hospitals may not be willing to make up the difference. Congress was probably concerned about the potential impact on families of absorbing even part of the cost of a medical crisis, when treatment for an individual can reach into the hundreds of thousands , and sometimes into the millions of dollars. *See, e.g., Daniel*; *Taylor*; *Liberty Life Assurance*, *supra*. Congress wanted COBRA to operate in a manner consistent with principles of giving

families experiencing qualifying events equal opportunities to health care coverage as those who remained in the group, *see Oakley*, 890 F.2d at 1133 ("[T]he statute speaks only in terms of identical coverage to be made available for a limited time. . . .") and the opportunity to exercise informed choice as to whether maintaining dual coverage is worth paying 102% of the total insurance cost. For many individuals who following a qualifying event might find themselves with only one health care plan, secondary coverage is not a "luxury," *Lutheran Hosp.*, 845 F. Supp. at 1287, but the difference between life and death, subsistence and financial ruin.

In making these decisions, it is important to recognize that pre-existing conditions are not the only reason that families might choose to maintain dual coverage. Today, at least:

> . . . 75% of insured American workers and their beneficiaries receive their health care through some type of "managed care" plan. As a strategy to control costs, most managed care plans perform utilization review prior or concurrent to a proposed course of treatment to determine if it is medically necessary. "By its very nature, a system of prospective decision-making influences the beneficiary's choice among treatment options. . . ." [I]n the managed care context, the wrongful denial of benefits by an insurer — whether intentional or the result of negligent medical decisions made during the utilization review process — will sometimes result in the beneficiary never receiving the treatment that she requires, and thus can lead to damages far beyond the out-of-pocket cost of the treatment at issue.

Andrews-Clarke v. Travelers Ins. Co., 21 Employee Benefits Cases 2137, 2146-74 (D. Mass. October 30, 1997) (citation omitted). Thus, some families maintain dual or secondary coverage, not only because of the possibility of significant

"gaps" due to deductions or exclusions from coverage, but because they want to be able to avoid the tender mercies of the "gatekeeper." Whether this is a "luxury" is certainly debatable — but if it is, it could be a luxury that Congress could reasonably want families to have.

The Court has recognized that certain principles govern the interpretation of remedial legislation — which — if there is to be any "interpretation" — bears consideration:

> Any exemption from such humanitarian and remedial legislation must therefore be narrowly construed, giving "due regard" for the plain meaning of statutory language and the intent of Congress. To extend an exemption to other than those plainly and unmistakably within its terms and spirit is to abuse the interpretive process and to frustrate the announced will of the people.

A.H. Phillips, Inc. v. Walling, 324 U.S. at 493, 65 S. Ct. at 808 (quotations added).

CONCLUSION

For the reasons outlined above, the decision of the Eighth Circuit should be reversed, and the case remanded for entry of an appropriate order, and further proceedings on the remaining counts of Petitioner's complaint.

Respectfully submitted,

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